Operational Policy Letter #55

Department Of Health & Human Services

Center for Health Plans and Providers

Health Care Financing Administration

Medicare Managed Care

September 5, 1997

BALANCED BUDGET ACT OF 1997

Issue/Question:

What are some of the major changes or impacts that the Balanced Budget Act (BBA) of 1997 will have for current Medicare risk or cost contractors?

Answer:

The attached document summarizes some of the key changes in the BBA which might impact current contractors. This document highlights new requirements or changes in existing requirements. It is not intended to be exhaustive. Additional information and guidance will be issued as policy decisions and statutory interpretations are made.

Contact:

HCFA Regional Office Managed Care Staff

September 5, 1997

NOTE TO: All Medicare Contracting Health Plans

SUBJECT: Medicare+Choice Program

Following is a brief description of recent legislative changes to the Medicare managed care program which may impact current contractors. The HCFA Center for Health Plans and Providers (CHPPs) will provide Medicare managed care contractors with additional information and guidance as policy decisions and statutory interpretations are made. We would urge current Medicare contractors to review this important legislation to determine how the provisions will affect various plan activities and objectives.

CONTRACTS WITH MEDICARE+CHOICE PLANS (Medicare Part C)

Public Law 105-33, The Balanced Budget Act of 1997, establishes a new authority permitting contracts between HCFA and a variety of different managed care and fee-for-service entities. The types of entities that may be granted contracts under this new authority include:

- **Coordinated care plans,** including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Provider-Sponsored Organizations (PSOs). A PSO is defined as a public or private entity established by health care providers, which provide a substantial proportion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk.
- **Religious fraternal benefit society plans** which may restrict enrollment to members of the church, convention or group with which the society is affiliated. Payments to such plans may be adjusted, as appropriate to take into account the actuarial characteristics and experience of plan enrollees.
- **Private fee-for-service plans** which reimburse providers on a fee-for-service basis, and are authorized to charge enrolled beneficiaries up to 115% of the plan's payment schedule (which may be different from the Medicare fee schedule).

In addition to the above Medicare+Choice contractors, beginning in January, 1999, up to 390,000 beneficiaries will have the choice (on a demonstration basis ending January 1, 2003) of enrolling in a **Medical Savings Account (MSA)** option. Under this option, beneficiaries would obtain high deductible health policies that pay for at least all Medicare-covered items and services after an enrollee meets the annual deductible of up to $6,000. The difference between the premiums for such high deductible policies and the applicable Medicare+Choice premium amount would be placed into an account for the beneficiary to use in meeting his or her deductible expenses.

Current 1876 Contracts: Current HMO/CMP risk plans that remain in compliance with current contracting standards and comply with new requirements established under this statutory authority will automatically transition into the Part C Medicare+Choice program. Beginning January 1, 1998, section 1876 risk-based contractors will be paid under a new Medicare+Choice payment methodology rather than the current AAPCC method in section 1876(a), and will be subject to certain other Medicare+Choice provisions. Contracting standards for Medicare+Choice plans (except for PSO solvency standards) will be published by June 1, 1998 as interim final regulations. Upon publication, the Secretary will no longer accept new 1876 risk applications. As of January 1, 1999, existing 1876 risk-based contracts will be terminated, and plans in good standing will transition to the Medicare+Choice program.

Repeal of Cost Option: As of August 5, 1997, the Secretary is prohibited from entering into any new 1876 cost-based contracts, unless the plan is a Health Care Prepayment Plan with an agreement under section 1833 of the Social Security Act. The 1876 cost-based payment authority is repealed and all cost contracts are terminated as of December 31, 2002.

Limited HCPP Option: Beginning January 1, 1999, the Secretary may only contract with those HCPPs that are sponsored by Union or Employer groups, or HCPPs that do not "provide, or arrange for the provision of, any inpatient hospital services ..." This amendment will result in the termination of 1833 agreements with any organization that does not meet the new definition. HCFA will establish transition rules for 1876 risk-based contractors that currently receive reimbursement on a cost basis for enrollees remaining under a previous HCPP agreement.

1876 Contracting Option for PSOs: During the transition, PSOs that are licensed by a State may be eligible organizations for purposes of obtaining a Medicare risk contract under section 1876. State licensed PSOs which apply for a risk contract would be required to meet all applicable standards for Competitive Medical Plans, except that the minimum enrollment requirements may be reduced or waived beginning January 1, 1998.

Medicare Subvention: The balanced budget amendment authorizes six (6) sites for a Medicare managed care subvention demonstration between HCFA and DoD. Under this demonstration DoD will be paid a reduced percentage of the Medicare+Choice reimbursement rate in return for providing Medicare covered services to eligible military retirees who are also eligible for Medicare. Enrollment is expected to begin in January of 1998, and for the first DoD managed care sites should begin providing health care services in February of 1998.

MEDICARE+CHOICE PROGRAM REQUIREMENTS

Unless otherwise noted, the following discussion is intended to summarize briefly only those statutory provisions which establish new Medicare+Choice program requirements, or amend existing contractual standards. New contractual standards will apply to 1876 risk plans which transition to the Medicare+Choice program for contract years beginning on January 1, 1999.

Beneficiary eligibility: Only beneficiaries entitled to Part A and enrolled in Part B are eligible to enroll in any Medicare+Choice plan that serves their geographic area. HCFA will promulgate rules to permit the continued enrollment of Part B-only enrollees in those 1876 risk-based plans that transition into the Medicare+Choice program.

According to rules to be determined by the Secretary, Medicare+Choice plans may allow beneficiaries who move out of the geographic area served by the Medicare+Choice plan to remain enrolled in the plan, provided those enrollees have reasonable access to the full range of covered services as part of the basic benefit package.

Contracting standards: By June 1, 1998, the Secretary will publish interim final regulations to establish standards for Medicare+Choice organizations. These standards will be based on existing requirements contained in Part 417 of the Public Health Title of the Code of Federal Regulations. All Medicare+Choice applications will be reviewed for compliance with the new standards, and 1876 risk plans that wish to transition to the

Medicare+Choice option will be required to meet the contracting standards for contract years beginning January 1, 1999.

Federal standards will preempt any State authority with regard to benefit requirements, requirements relating to inclusion of or treatment by providers, and coverage determinations (including related appeals and grievance processes).

(NOTE: Fiscal solvency standards for PSOs will be established on a different track.)

Special Information Campaign: During November 1998 the Secretary will conduct an educational campaign to inform Medicare beneficiaries about the availability of Medicare+Choice plans, and plans with Medicare risk contracts. Current 1876 risk contractors must accept new enrollees during this period.

Enrollment: Beginning in November of 1999, the Secretary will provide for an annual national educational and publicity campaign to inform eligible beneficiaries about their Medicare+Choice plan options. Beneficiary plan choice is effective January 1 of the following year. Newly eligible enrollees who do not choose a Medicare+Choice plan are deemed to have chosen the original Medicare fee-for-service option, except that the Secretary may establish procedures under which "age-ins" enrolled in a contracting plan may be deemed to have elected the entity's Medicare+Choice plan.

Any beneficiary who is enrolled in a 1876 plan as of December 31, 1998 will be considered to be enrolled with that organization under the Medicare+Choice program if the plan is granted a Medicare+Choice contract beginning January 1, 1999.

Disenrollment: Starting in 2002, beneficiaries who are enrolled in a Medicare+Choice coordinated care plan will be able to disenroll from their elected plan option once during the first 6 months of 2002. Beneficiaries who enroll in a Medicare+Choice plan at the time they become eligible for Medicare will be permitted to disenroll at any time during the first year of enrollment.

Beginning January 1, 2003, beneficiaries may only disenroll from a Medicare+Choice coordinated care plan and choose another plan, leave Medicare fee-for-service to enroll in a Medicare+Choice plan, or return to Medicare fee-for-service, one time during the first 3 months of the calendar year. Beneficiaries will be effectively locked in to their Medicare+Choice plan election for the remaining nine months following this window. Exceptions to the lock-in period are available for enrollees under the following circumstances: the Medicare+Choice plan contract is terminated, the beneficiary leaves the plan service area, the Medicare+Choice plan fails to provide covered benefits or is found to be improperly marketing the Medicare product, or under other conditions specified by the Secretary.

Medicare+Choice plans may disenroll Medicare beneficiaries if it is determined that the enrollee was disruptive to plan operations, or failed to pay required premiums on a timely basis.

Coordinated Open Enrollment Period: In November 1999, the Secretary will hold the first annual coordinated open enrollment period to allow eligible beneficiaries to enroll in Medicare+Choice plans. Medicare+Choice plans will be required to submit comparative information to the Secretary.

Marketing Material Approval: If a Medicare+Choice plan's marketing materials were approved for one service area, they will be deemed to be approved in all of the plan's service areas, except with regard to area-specific information. Medicare+Choice plans are prohibited from giving monetary incentives as an inducement to enroll, and from completing any portion of the enrollment application.

Benefits: Public Law 105-33 establishes some new preventive benefits, and increases coverage for others. The updates to payment rates for current 1876 risk contractors and Medicare+Choice plans will reflect the costs of these new benefits.

BENEFIT	EFFECTIVE DATE
Annual Screening Mammography (for women over 40)	January 1, 1998
Screening PAP Smear and Pelvic Exam (every 3 years)	January 1, 1998
Colorectal Cancer Screening Exam	January 1, 1998
Bone Density Measurement (to rule out Osteoporosis)	July 1, 1998
Prostate Cancer Screening Exam (for men over 50)	January 1, 2000

Disclosure: The Medicare+Choice plan must provide in a clear, accurate and standardized form certain information to each enrollee such as the plan's service area, benefits, number, mix and distribution of providers, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, appeals and grievance procedures and quality assurance program. Upon request, enrollees must be provided comparative information, information on the plan's utilization control mechanisms, information on the number of grievances and appeals and their disposition in the aggregate and a summary of physician compensation arrangements.

Access to non-network providers: Medicare+Choice plans must cover services provided by non-network providers in the case of urgent care that is medically necessary when the enrollee is out of the plan service area, renal dialysis services for enrollees who are temporarily out of the plan's service area, and maintenance or post-stabilization care after an emergency condition has been stabilized.

Medicare+Choice plans are required to pay for emergency services without regard to prior authorization or the emergency provider's status as a network provider. An emergency medical condition is defined using a "prudent layperson" standard which may include the beneficiary's assertion of "severe pain".

QA Program: Medicare+Choice plans must undergo external quality reviews by independent review organizations. The Secretary is authorized to waive the external review requirement if the Medicare+Choice plan can demonstrate a record of excellence in meeting quality assurance standards, and compliance with other applicable requirements. Plans could be deemed to meet internal quality assurance requirements by becoming accredited by a private organization approved by the Secretary.

Providers: Medicare+Choice plans must establish procedures relating to physician participation in the plan, including notice of rules of participation, written notice of adverse participation decisions, and an appeals process. Medicare+Choice plans must consult with participating physicians regarding medical policy, quality and medical management procedures.

Medicare+Choice plans are prohibited from requiring contracting providers to indemnify the plan against actions resulting from the plan's denial of medically necessary care.

Plans may not restrict health care professionals' advice to enrollees regarding the beneficiary's health status or treatment options. The Act includes a "conscience protection" clause exempting a plan from being required to provide or cover a counseling or referral service if the plan (1) objects on moral or religious grounds, and (2) informs prospective enrollees of such policy before or during enrollment, and current enrollees within 90 days after adopting a change in such policy.

Minimum enrollment: Medicare+Choice plans will be required to meet the following minimum enrollment requirements: 5000 for HMOs, PPOs, and FFS plans in urban areas, and 1500 for PSOs; 1500 for HMOs, PPOs, and FFS plans in rural areas, 500 for PSOs. These requirements could be waived in the first 3 contract years.

The enrollment composition requirements, (known as the "50/50 rule") no longer counts Medicaid enrollees in the federal portion of the enrollment mix. The Secretary is given immediate explicit authority to waive the 50/50 requirement for contract years beginning January 1, 1997. The 50/50 requirement is repealed as of January 1, 1999.

Annual Audit: The Secretary must annually audit the financial records annually of at least one third of Medicare+Choice plans. The audit will include review of data related to Medicare utilization, costs, and computation of the ACR, and will be monitored by the GAO.

Plan User Fees: Medicare+Choice plans and section 1876 contractors must contribute their pro rata share, as determined by the Secretary, of estimated costs related to enrollment and dissemination of information and certain counseling and assistance programs. The Secretary is authorized to collect user fees but such fees are limited to $200 million in fiscal year 1998, $150 million in fiscal year 1999 and $100 million in fiscal year 2000 and beyond.

Payment: The 1998 payment rates for 1876 risk-based contracts and new Medicare+Choice plans will be announced on September 8, 1997. On **March 1**, beginning in 1998, the Medicare+Choice payment rates will be announced for the following contract year. In general, beginning in 1998 Medicare capitation rates to plans will be the greater of:

- a blend of the input-price adjusted national rate and an area-specific rate, adjusted by a budget neutrality factor. The area-specific rate will be based on 1997 rates, and adjusted to reflect 1) a national average Medicare per capita growth rate, and 2) gradual removal of IME/GME costs;
- a minimum payment amount of $367 for 1998, not to exceed 150% of the prior year rate, adjusted annually by a defined update factor; or
- a minimum percentage increase (2% per year).

The 1997 capitation rates (from the 1997 AAPCC ratebook) will be the base for (1) the area specific rates in the blend and (2) the minimum percentage increase rates. In an area where the 1997 AAPCC varies by more than 20 percent from the 1996 AAPCC, the Secretary can substitute for the 1997 rate a rate more indicative of the cost of enrollees in the area.

The update factor for the area specific rates in the blend and the minimum payment amount will be the national average per capita Medicare+Choice growth rate, reduced by 0.8 percentage points for 1998, and 0.5 percentage points for 1999 through 2002, and 0.0 percentage points thereafter**.**

The payment area is the county or equivalent area specified by the Secretary. Beginning in 1999, states would be able to request a statewide payment rate, or rates based on Metropolitan Statistical Areas and a statewide rural area. Such changes would be subject to a budget neutrality requirement.

Reporting of Encounter Data: Beginning January 1, 1998, the Secretary will require that current Medicare managed care contractors submit hospital encounter data covering the period beginning July 1, 1997. Beginning on or after July 1, 1998, the Secretary has the authority to establish other encounter data reporting requirements for Medicare+Choice plans, including current 1876 risk contractors that transition to the new program on January 1, 1999.

Premiums: Beginning in 1998, by May 1 all Medicare+Choice coordinated care plans including HMOs, PSOs, and PPOs must submit adjusted community rate (ACR) proposals for basic and supplemental benefits, the plan's premium for the basic and supplemental benefits, a description of cost sharing and theactuarial value of cost sharing for basic and supplemental benefits and a description of any additional benefits and the value of these benefits.

State taxes: States may no longer tax the premium revenue of Medicare+Choice plans.

Provision of Information: As part of the monitoring and compliance process, Medicare+Choice plans must disclose financial information to demonstrate fiscal soundness, including data related to business transactions concerning property transfers and trades, loans, and extensions of credit.

Please see the attachment for additional information regarding implementation deadlines. While CHPPs staff is available to assist plans with specific implementation issues and questions, it is important for all Medicare contractors to study the legislative language in order to ascertain how these changes will affect your operations.

Sincerely,

Bruce Merlin Fried

Director

Attachment

IMPLEMENTATION

(Selected Key Dates)

PROVISION	DATE
Enactment of the Balanced Budget Act of 1997, Public Law 105-33	August 5, 1997
Convening notice for negotiated rulemaking to establish federal solvency standards for PSOs published in FR	September 19, 1997
Medicare+Choice plans begin reporting encounter data	January 1, 1998
Fiscal solvency standards for PSOs published in the FR	April 1, 1998
Interim final reg with contracting standards for Medicare+Choice plans published in FR	June 1, 1998
Special information campaign to inform eligible beneficiaries about Medicare+Choice	November 1, 1998

options -1876 risk plans must accept any new enrollees during the coordinated information campaign	
1876 risk-based plans must transition to Medicare+Choice program	January 1, 1999
Elimination of HCPP option for entities eligible to contract as Medicare+Choice managed care plan	January 1, 1999
Termination of 1876 cost contracts	January 1, 2003